

Postnatal care

Quality standard

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This standard is based on PH11, PH27, PH40, CG37 and CG192.

This standard should be read in conjunction with QS4, QS22, QS32, QS35, QS3, QS15, QS57, QS75, QS64, QS62, QS60, QS46, QS94, QS98, QS109, QS112, QS115, QS128, QS129 and QS169.

Introduction

This quality standard covers postnatal care, which includes the core care and support that every woman, their baby and if appropriate, their partner and family should receive during the postnatal period. This includes recognising women and babies with additional care needs and referring them to specialist services. For more information see the [scope](#) for this quality standard.

Why this quality standard is needed

Postnatal care is the individualised care provided to meet the needs of a mother and her baby following childbirth. Although the postnatal period is uncomplicated for most women and babies, care during this period needs to address any variation from expected recovery after birth. For the majority of women, babies and families, the postnatal period ends 6–8 weeks after the birth. However for some women and babies, the postnatal period should be extended in order to meet their needs. This is particularly important where a woman or baby has developed complications and remains vulnerable to adverse outcomes. For example, this could include women who have poor support networks, have developed a postnatal infection or other health problem that is continuing to impact on their daily lives, or women who are at risk of mental health problems or infant attachment problems.

How this quality standard supports delivery of outcome frameworks

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2013–14](#)
- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–16, [Part 1](#) and [Part 1A](#).

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [NHS Outcomes Framework 2013–14](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p>Overarching indicator</p> <p>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare</p> <p>Improvement area</p> <p>Reducing deaths in babies and young children</p> <p>1.6i Infant mortality*</p> <p>1.6ii Neonatal mortality and stillbirths</p>
4 Ensuring that people have a positive experience of care	<p>Overarching indicator</p> <p>4a Patient experience of primary care</p> <p>4c Friends and family test (placeholder)</p> <p>Improvement area</p> <p>Improving women and their families' experience of maternity services</p> <p>4.5 Women's experience of maternity services</p>

5 Treating and caring for people in a safe environment and protecting them from avoidable harm	<p>Improvement areas</p> <p>Reducing the incidence of avoidable harm</p> <p>5.1 Incidence of hospital-related venous thromboembolism (VTE)</p> <p>Improving the safety of maternity services</p> <p>5.5 Admission of full-term babies to neonatal care</p>
<p>Alignment across the health and social care system</p> <p>* Indicator shared with Public Health Outcomes Framework (PHOF)</p>	

Table 2 Public health outcomes framework for England, 2013–16

Domain	Objectives and indicators
2 Health improvement	<p>Objective</p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators</p> <p>2.2 Breastfeeding</p> <p>2.5 Child development at 2–2.5 years (Placeholder)</p> <p>2.11 Diet</p> <p>2.12 Excess weight in adults</p> <p>2.13 Proportion of physically active and inactive adults</p>
4 Healthcare public health and preventing premature mortality	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p>Indicators</p> <p>4.1 Infant mortality*</p> <p>4.3 Mortality from causes considered preventable**</p>
<p>Alignment across the health and social care system</p> <p>* Indicator shared with NHS Outcomes Framework</p> <p>** Indicator complementary with NHS Outcomes Framework</p>	

Coordinated services

The quality standard for postnatal care specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the postnatal component of the maternity care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to women, babies, partners and other family members.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality postnatal care service are listed in [related quality standards](#).

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care practitioners involved in assessing and caring for women and babies should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

List of quality statements

In the statements the term 'women' is used to refer to mothers of babies.

Statement 1 The woman and baby's individualised postnatal care plan is reviewed and documented at each postnatal contact.

Statement 2 Women are advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

Statement 3 Women or main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Statement 4 Women, their partner or the main carer are given information on the association between co-sleeping and sudden infant death syndrome (SIDS) at each postnatal contact.

Statement 5 Women receive breastfeeding support from a service that uses an evaluated, structured programme.

Statement 6 Information about bottle feeding is discussed with women or main carers of formula-fed babies.

Statement 7 Babies have a complete 6–8 week physical examination.

Statement 8 Women with a body mass index (BMI) of 30 kg/m² or more at the 6–8 week postnatal check are offered a referral for advice on healthy eating and physical activity.

Statement 9 Women have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact.

Statement 10 Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems.

Statement 11 Parents or main carers who have infant attachment problems receive services designed to improve their relationship with their baby.

Other quality standards that should also be considered when choosing, commissioning or providing a high-quality postnatal care service are listed in [related NICE quality standards](#).

Quality statement 1: Continuity of care

Quality statement

The woman and baby's individualised postnatal care plan is reviewed and documented at each postnatal contact.

Rationale

Postnatal care should be a continuation of the care the woman received during her pregnancy, labour and birth. Planning and regularly reviewing the content and timing of care, for individual women and their babies, and communicating this (to the woman, her family and other relevant postnatal care team members) through a documented care plan can improve continuity of care.

Quality measures

Structure

Evidence of local arrangements to ensure that the woman and her baby's individualised postnatal care plan is reviewed and documented at each postnatal contact.

Data source: Local data collection.

Process

The proportion of women and their babies who have an individualised and documented postnatal care plan, which is reviewed at each postnatal contact.

Numerator – the number of contacts in which the woman and baby's individualised postnatal care plan is reviewed and documented.

Denominator – the number of postnatal contacts.

Data source: Local data collection, for example audit of patient health records.

Outcome

Women's satisfaction with the continuity and content of their postnatal care.

Data source: Local data collection. The Care Quality Commission [Maternity services survey 2018](#) collected information about women's experiences of maternity care.

What the quality statement means for different audiences

Service providers ensure that systems are in place to provide women and their babies with an individualised postnatal care plan, which is reviewed and documented at each postnatal contact.

Healthcare practitioners provide women and their babies with an individualised postnatal care plan, which is reviewed and documented at each postnatal contact.

Commissioners ensure that they commission services in which women are provided with an individualised postnatal care plan, which is reviewed and documented at each postnatal contact.

Women and their babies have an individualised postnatal care plan, which is reviewed and documented at each postnatal contact.

Source guidance

[Postnatal care up to 8 weeks after birth](#) (2015) NICE guideline CG37, recommendation 1.1.3 (key priority for implementation)

Definitions of terms used in this quality statement

Postnatal care plan

The individualised postnatal care plan should be documented and developed with the woman, ideally in the antenatal period or as soon as possible after birth. The plan should be comprehensive and include as a minimum:

- relevant factors from the antenatal, intrapartum and immediate postnatal period
- details of a named midwife or health visitor, including a 24-hour telephone number to enable the woman to contact her named healthcare practitioner or an alternative practitioner should

- he or she not be available
- details of the healthcare practitioners involved in her care and that of her baby, including roles and contact details
- plans for the postnatal period including:
 - specific plans for managing pregnancy-related conditions when they occur, such as gestational hypertension, pre-eclampsia, thromboembolism, gestational diabetes, postnatal wound care and mental health conditions
 - details about adjustment to motherhood, emotional wellbeing and family support structures
 - plans for feeding, including specific advice about either breastfeeding support or formula feeding
 - plans for contraceptive care.

[Definition adapted with expert group consensus from NICE's guideline on postnatal care up to 8 weeks after birth, recommendation 1.1.3]

Postnatal contact

Women and their babies should receive the number of postnatal contacts appropriate to their care needs. A postnatal contact is a scheduled postnatal appointment which may occur in the woman or baby's home or another setting such as a GP practice or children's centre. Where a woman remains in hospital following delivery, her postnatal care plan should be reviewed on a daily basis until her transfer home and then reviewed at each subsequent contact.

Equality and diversity considerations

Communication and information-giving between women (and their families) and members of the maternity team is a key aspect of this statement. The individualised postnatal care plan and the information within it should be accessible to women, including women who do not speak or read English and those with additional needs such as physical, sensory or learning disabilities.

Quality statement 2: Maternal health – life-threatening conditions

Quality statement

Women are advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

Rationale

Women are at increased risk of experiencing serious health events in the immediate hours, days and weeks following the birth, some of which could lead to maternal death or severe morbidity. Providing women with information about the symptoms and signs that may indicate a serious physical illness or mental health condition may prompt them to access immediate emergency treatment if needed. Emergency treatment could potentially avoid unnecessary deaths and severe morbidity.

Quality measures

Structure

Evidence of local arrangements to ensure that women are advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten her life and require her to access emergency treatment.

Data source: Local data collection.

Process

The proportion of women who are advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten her life and require her to access emergency treatment.

Numerator – the number of women in the denominator who are advised, within the first 24 hours, after birth of the symptoms and signs of conditions that may threaten her life and require her to access emergency treatment.

Denominator – the number of women who have given birth.

Data source: Local data collection.

Outcome

a) Incidence of potentially avoidable maternal morbidity and mortality.

Data source: Local data collection. The [Maternal, Newborn and Infant Clinical Outcome Review Programme](#) (undertaken by MBRRACE-UK) reports on rates of maternal death and severe maternal morbidity.

b) Women feel informed about symptoms and signs of postnatal life-threatening conditions.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women to be advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

Healthcare practitioners advise women, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

Commissioners ensure that they commission services that advise women, within 24 hours of the birth, of conditions that may threaten their lives and require them to access emergency treatment.

Women are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions that should prompt her to call for emergency treatment.

Source guidance

- [Postnatal care up to 8 weeks after birth](#) (2015) NICE guideline CG37, recommendation 1.2.1 (key priority for implementation) and 1.2.4
- [Antenatal and postnatal mental health: clinical management and service guidance](#) (2014) NICE

- guideline CG192, recommendations 1.4.1, 1.4.3 and 1.4.6
- Bacterial sepsis following pregnancy (2012) Royal College of Obstetricians and Gynaecologists (RCOG). Green-top guideline no. 64b, Section 17

Definitions of terms used in this quality statement

First postnatal contact

The first postnatal contact should occur within 24 hours after the birth.

[Based on expert opinion]

Information provision

The woman should receive accurate, evidence-based verbal and written information. If the woman is too unwell to receive this information within the first 24 hours after the birth, the information should be discussed once the woman has made a recovery and is able to identify symptoms and signs of life-threatening conditions in herself. All women should also be provided with a contact number that can be used at any time of the day or night to seek urgent maternity advice (for example, the labour ward triage number).

Symptoms and signs of life-threatening physical conditions

The following symptoms and signs are suggestive of potentially life-threatening physical conditions in the woman:

- sudden and profuse blood loss or persistent, increased blood loss
- faintness, dizziness or palpitations or tachycardia
- fever, shivering, abdominal pain, especially if combined with offensive vaginal loss or a slow-healing perineal wound
- headaches accompanied by visual disturbances or nausea or vomiting within 72 hours of birth
- leg pain, associated with redness or swelling
- shortness of breath or chest pain
- widespread rash.

[Definition adapted with expert group consensus from NICE's guideline on [postnatal care up to 8 weeks after birth](#), recommendation 1.2.1, table 2]

Symptoms and signs of life-threatening mental health conditions

The following symptoms and signs are suggestive of potentially life-threatening mental health conditions in the woman:

- severe depression, such as feeling extreme unnecessary worry, being unable to concentrate due to distraction from depressive feelings
- severe anxiety, such as uncontrollable feeling of panic, being unable to cope or becoming obsessive
- the desire to hurt others or yourself, including thoughts about taking your own life
- confused and disturbed thoughts, which could include other people telling you that you are imagining things (hallucinations and delusions).

[Definition adapted with expert group consensus from [RCOG's Good practice guidance no. 14](#), section 5]

Equality and diversity considerations

Communication and information-giving between women (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who do not speak or read English.

Written and verbal information should be appropriate for the woman's level of literacy, culture and language.

Quality statement 3: Infant health – life-threatening conditions

Quality statement

Women or main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Rationale

Babies may experience serious health conditions in the immediate hours, days and weeks following the birth, which can lead to severe illness or in rare cases, death. Providing the mother or main carer with verbal and written information about the symptoms and signs that might indicate their baby has a serious health problem may result in emergency treatment being sought more promptly. This information should be provided within 24 hours of the birth.

Quality measures

Structure

Evidence of local arrangements to ensure that the women or main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Data source: Local data collection.

Process

The proportion of women or main carers of the baby who are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Numerator – the number of women or main carers of babies who are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Denominator – the number of mothers or main carers of babies.

Data source: Local data collection.

Outcome

a) Incidence of potentially avoidable infant morbidity and mortality.

Data source: Local data collection. The [Maternity Services Data Set](#) collects data on neonatal deaths. The [Perinatal mortality surveillance report](#) (MBRRACE-UK) reports on rates of perinatal death.

b) Women and main carers feel informed about symptoms and signs of potentially life-threatening conditions in the baby.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women or main carers of babies to be advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Healthcare practitioners advise women or main carers of babies, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Commissioners ensure that they commission services that advise women or main carers of babies, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Women or the main carer of the baby are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Source guidance

[Postnatal care up to 8 weeks after birth](#) (2015) NICE guideline CG37, recommendations 1.4.2 (key

priority for implementation), 1.4.17 and 1.4.31 and expert group consensus

Definitions of terms used in this quality statement

First postnatal contact

The first postnatal contact should occur within 24 hours after the birth.

[Based on expert opinion]

Information provision

The woman or main carer of the baby should receive accurate, evidence-based verbal and written information. If the baby is unwell and in hospital, the information should be provided to the mother or main carer prior to the baby's discharge.

The woman or main carer of the baby should also be provided with a contact number that can be used at any time of the day or night to seek urgent advice (for example, the labour ward triage number). The woman or main carer of the baby should be advised to contact the emergency services if they are very concerned about their baby's health.

Symptoms and signs of life-threatening conditions in the baby (0–3 months)

The following symptoms and signs are suggestive of potentially life-threatening physical conditions in the baby (0–3 months):

A major change in the baby's behaviour, for example:

- less active than usual
- less responsive than usual
- more irritable than usual
- breathing faster than usual or grunting when breathing
- feeding less than usual
- nappies much less wet than usual

- has blue lips
- is floppy
- has a fit
- has a rash that does not fade when pressed with a glass
- vomits green fluid
- has blood in their stools
- has a bulging or very depressed fontanelle
- has a temperature higher than 38°C
- with the exception of hands and feet, feels cold when dressed appropriately for the environment temperature
- within the first 24 hours after the birth:
 - has not passed urine
 - has not passed faeces (meconium)
 - develops a yellow skin colour (jaundice).

[Adapted with expert group consensus from information provided in the Department of Health's Birth to Five book, NICE's guideline on neonatal infection (early onset), table 2, and NICE's guideline on fever in under 5s]

Main carer

For the majority of babies the main carer will be the mother. For some babies the main carer could be a close relative, for example the baby's father or grandparent, or for looked-after babies this could be a foster parent.

Equality and diversity considerations

Communication and information-giving between women (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who do not speak or read English.

Quality statement 4: Infant health – safer infant sleeping

Quality statement

Women, their partner or the main carer are given information on the association between co-sleeping and sudden infant death syndrome (SIDS) at each postnatal contact.

Rationale

Although the cause of SIDS is unknown, there are specific behaviours that may make SIDS more likely. There is some evidence that where co-sleeping occurs there may be an increase in the number of cases of SIDS. Giving information to women, their partner or the main carer about this association will support them to establish safer infant sleeping habits, and may reduce the likelihood of SIDS.

Quality measures

Structure

Evidence of local arrangements to ensure that women, their partner or the main carer are given information on the association between co-sleeping and SIDS at each postnatal contact.

Data source: Local data collection.

Process

a) Proportion of women, their partners or main carers of newborn babies who are given information on the association between co-sleeping and SIDS within 24 hours of the birth.

Numerator – the number of women, their partners or main carers of newborn babies who are given information on the association between co-sleeping and SIDS within 24 hours of the birth.

Denominator – the number of newborn babies.

Data source: Local data collection.

b) Proportion of women, their partners or main carers of newborn babies who are given information on the association between co-sleeping and SIDS at every postnatal contact.

Numerator – the number of postnatal contacts in which women, their partners or main carers of newborn babies are given information on the association between co-sleeping and SIDS.

Denominator – the number of postnatal contacts.

Data source: Local data collection.

c) Proportion of women, their partners or main carers of newborn babies who are given information on the association between co-sleeping and SIDS at a postnatal contact 10–14 days after the birth (at the midwifery and health visitor handover when the woman and baby are discharged from the care of the community midwifery team to the care of the health visitor).

Numerator – the number of women, their partners or main carers of newborn babies who are given information on the association between co-sleeping and SIDS at a postnatal contact 10–14 days after the birth.

Denominator – the number of newborn babies.

Data source: Local data collection.

d) Proportion of women, their partners or main carers of newborn babies who are given information on the association between co-sleeping and SIDS at the 6–8 week postnatal check.

Numerator – the number of women, their partners or main carers of newborn babies who are given information on the association between co-sleeping and SIDS at the 6–8 week postnatal check.

Denominator – the number of newborn babies.

Data source: Local data collection.

Outcome

a) Incidence of SIDS.

Data source: Office for National Statistics report [Unexplained deaths in infancy – England and](#)

Wales: 2017.

b) Women, their partners and the main carers of babies know about the association between co-sleeping and SIDS.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that information about the association between co-sleeping and SIDS is available, and that healthcare professionals are trained to understand and explain the information and to give it to women, their partners or the main carers of babies at every postnatal contact.

Healthcare practitioners ensure that they understand and can explain information about the association between co-sleeping and SIDS, and that they give this information to women, their partners or the main carers of babies at every postnatal contact.

Commissioners ensure that they commission services that provide information about the association between co-sleeping and SIDS, and that train healthcare professionals to understand and explain this information and give it to women, their partners or the main carers of babies at every postnatal contact.

Women, their partner or the main carer of babies are given information at every postnatal contact about the link between sleeping with their baby (this is called co-sleeping and includes sleeping with them on a sofa or chair as well as in bed) and sudden infant death syndrome. Sudden infant death syndrome is the sudden, unexpected and unexplained death of a seemingly well baby. It is rare and no one knows what causes it. Some things, such as co-sleeping, may make sudden infant death syndrome more likely.

Source guidance

Postnatal care up to 8 weeks after birth (2015) NICE guideline CG37, recommendations 1.4.45 and 1.4.47

Definitions of terms used in this quality statement

Co-sleeping

Parents or carers sleeping on a bed or sofa or chair with an infant.

[NICE's guideline on [postnatal care up to 8 weeks after birth](#), recommendation 1.4.47]

Main carer

For the majority of babies the main carer will be the mother. For some babies the main carer could be a close relative, for example the baby's father or grandparent, or for looked-after babies this could be a foster parent.

Postnatal contact

Women and their babies should receive the number of postnatal contacts appropriate to their care needs. A postnatal contact is a scheduled postnatal appointment that may occur in the woman or baby's home, a GP practice or children's centre, or a hospital setting if the woman or baby needs extended inpatient care. For the majority of women, babies and families the postnatal period ends 6–8 weeks after the birth.

Equality and diversity considerations

Communication and information-giving between women (and their families or the main carer) and members of the maternity team are key aspects of this statement. Relevant adjustments should be in place for people with communication difficulties, and those who do not speak or read English. Verbal and written information should be appropriate for the person's level of literacy, culture, language and family circumstances. Co-sleeping can be intentional or a necessity, but all women, their partners or main carers of babies should be given information in a format they can understand, irrespective of their culture.

Quality statement 5: Breastfeeding

Quality statement

Women receive breastfeeding support from a service that uses an evaluated, structured programme.

Rationale

Breastfeeding contributes to the health of both the mother and child in the short and longer term. Women should be made aware of these benefits and those who choose to breastfeed should be supported by a service that is evidence-based and delivers an externally audited, structured programme. Delivery of breastfeeding support should be coordinated across the different sectors.

Quality measures

Structure

Evidence of local arrangements for breastfeeding support to be provided through a service that uses an evaluated, structured programme.

Data source: Local data collection.

Process

a) Proportion of women who receive breastfeeding support through a service that uses an evaluated, structured programme.

Numerator – the number of women in the denominator who receive breastfeeding support through a service that uses an evaluated, structured programme.

Denominator – the number of women who breastfeed (exclusively or partially).

Data source: Local data collection.

b) Proportion of women who wanted to continue breastfeeding but stopped before they had planned to.

Numerator – the number of women who wanted to continue breastfeeding but stopped before they had planned to.

Denominator – the number of women who breastfed (exclusively or partially).

Data source: Local data collection.

Outcome

a) Rates of breastfeeding initiation.

Data source: The [Maternity Services Data Set](#) reports percentage of babies receiving breast milk as first feed.

b) Rates of exclusive or partial breastfeeding on discharge from hospital and at 6–8 weeks after the birth.

Data source: Contained within the [Maternity Services Data Set](#), [Public Health England: Breastfeeding at 6 to 8 weeks after birth data reports](#), the [Children and Young People's Health Services Secondary Uses Data Set](#) and the NHS England [Maternal 12 week risk assessment](#).

c) Women's satisfaction with breastfeeding support.

Data source: The Care Quality Commission [Maternity services survey 2018](#) collected information about women's experiences of maternity care and this included a section on infant feeding.

What the quality statement means for different audiences

Service providers ensure that women receive breastfeeding support through a service that uses an evaluated, structured programme.

Healthcare practitioners ensure that women receive breastfeeding support through an integrated service that uses an evaluated, structured programme.

Commissioners ensure that they commission a service that delivers breastfeeding support through an evaluated, structured programme.

Women receive breastfeeding support through a service that uses an evaluated, structured programme.

Source guidance

- [Postnatal care up to 8 weeks after birth](#) (2015) NICE guideline CG37, recommendation 1.3.3 (key priority for implementation)
- [Maternal and child nutrition](#) (2008) NICE guideline PH11, recommendations 1 (key priority for implementation) and 7 (key priority for implementation)

Definitions of terms used in this quality statement

Structured programme

All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the [UNICEF Baby Friendly Initiative](#) as a minimum standard. If providers implement a locally developed programme, this should be evidence-based, structured, and undergo external evaluation. The structured programme should be delivered and coordinated across all providers, including hospital, primary, community and children's centre settings. Breastfeeding outcomes should be monitored across all services.

[Adapted from NICE's guidelines on [postnatal care up to 8 weeks after birth](#), recommendation 1.3.3, and [maternal and child nutrition](#), recommendation 7]

Breastfeeding support

All people involved in delivering breastfeeding support should receive the appropriate training and undergo assessment of competencies for their role. This includes employed staff and volunteer workers in all sectors, for example, hospitals, community settings, children's centres and peer supporter services.

Equality and diversity considerations

Breastfeeding support should be culturally appropriate and accessible to people with additional needs, such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women should have access to an interpreter or advocate if needed. Special consideration will be needed if the mother and baby have been separated for any reason, for example if the baby

has been admitted to neonatal care or the baby has been taken into care.

Quality statement 6: Formula feeding

Quality statement

Information about bottle feeding is discussed with women or main carers of formula-fed babies.

Rationale

Babies who are fully or partially formula fed can develop infections and illnesses if their formula milk is not prepared safely. In a small number of babies these cause serious harm and are life threatening, and require the baby to be admitted to hospital. The mother or main carer of the baby needs consistent, evidence-based advice about how to sterilise feeding equipment and safely prepare formula milk.

Quality measures

Structure

Evidence of local arrangements to ensure that information about bottle feeding is discussed with women or main carers of formula-fed babies.

Data source: Local data collection.

Process

The proportion of women or main carers of formula-fed babies who have information about bottle feeding discussed with them.

Numerator – the number of women or main carers in the denominator who have information about bottle feeding discussed with them.

Denominator – the number of women or main carers of formula-fed babies.

Data source: Local data collection.

Outcome

a) Rates of hospital admissions for formula feeding-related conditions.

Data source: Local data collection.

b) Women's and main carers' knowledge of how to sterilise feeding equipment and safely prepare formula milk.

Data source: Local data collection, for example use of patient surveys. The [Infant feeding survey 2010](#) collected self-report data on how mothers prepared powdered formula feed in the last 7 days, including whether they had followed all 3 recommendations for making up feeds (only making 1 feed at a time; making feeds within 30 minutes of the water boiling; and adding the water to the bottle before the powder).

c) Women's and main carers' satisfaction with feeding support.

Data source: The Care Quality Commission [Maternity services survey 2018](#) collected information about women's experiences of maternity care and this included a section on infant feeding.

What the quality statement means for different audiences

Service providers ensure that information about bottle feeding is discussed with women or main carers of formula-fed babies.

Healthcare practitioners discuss information about bottle feeding with women or main carers of formula-fed babies.

Commissioners ensure that they commission services in which information about bottle feeding is discussed with women or main carers of formula-fed babies.

Women or main carers of formula-fed babies have the opportunity to discuss information about bottle feeding.

Source guidance

[Postnatal care up to 8 weeks after birth](#) (2015) NICE guideline CG37 recommendations 1.3.42,

1.3.43 and 1.3.45

Definitions of terms used in this quality statement

Formula-fed baby

This statement relates to mothers and main carers who totally or partially formula feed their baby, and breastfeeding mothers who plan to formula feed their baby.

Information provision

The woman or main carer of the baby should receive accurate, evidence-based information that includes written information about formula feeding.

To ensure the mother or main carer has a good understanding of how to prepare formula feeds, it may be appropriate to give a demonstration as well as discussing bottle feeding.

Main carer

For the majority of babies the main carer will be the mother. For some babies the main carer could be a close relative, for example the baby's father or grandparent, or for looked-after babies this could be a foster parent.

Equality and diversity considerations

Communication and information-giving between women (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who don't speak or read English. Verbal and written information should be appropriate in terms of women's (and their families) level of literacy, culture, language and family circumstances.

Quality statement 7: Infant health – physical examination

Quality statement

Babies have a complete 6–8 week physical examination.

Rationale

The purpose of the examination is to identify babies more likely to have conditions that would benefit from further investigation and management. This includes an overall physical examination as well as screening for eye problems, congenital heart defects, developmental dysplasia of the hip and undescended testicles. Most babies will be healthy, but the small number of babies who do have serious problems will benefit from prompt identification. Early treatment can improve the health of the baby and prevent or reduce disability.

Quality measures

Structure

a) Evidence of local arrangements to ensure that parents or main carers of babies are offered an appointment for the baby to attend for a 6–8 week physical examination.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that a system is in place to monitor the competency of practitioners undertaking a 6–8 week physical examination.

Data source: Local data collection.

Process

Proportion of babies who had a 6–8 week physical examination.

Numerator – the number in the denominator who had a 6–8 week physical examination.

Denominator – the number of babies aged 8 weeks.

Data source: Local data collection.

Outcomes

a) Incidence of physical abnormalities in babies.

Data source: Local data collection.

b) Health outcomes associated with early intervention for babies with physical abnormalities.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that babies are offered a complete 6–8 week physical examination.

Healthcare practitioners ensure that they perform a complete 6–8 week physical examination of babies and that they maintain the necessary competencies for this role.

Commissioners ensure that they commission services that offer a complete 6–8 week physical examination for babies, which is carried out in timely manner and by a competent practitioner.

The mother or main carer of the baby is given the opportunity for their baby to have a complete 6–8 week physical examination, which is carried out in timely manner and by a competent practitioner.

Source guidance

[Postnatal care up to 8 weeks after birth](#) (2015) NICE guideline CG37, recommendation 1.4.11 and 1.4.13

Definitions of terms used in this quality statement

6–8 week physical examination

NICE's guideline on [postnatal care up to 8 weeks after birth](#), recommendations 1.4.11 and 1.4.13 detail the components of the 6–8 week physical examination.

Quality statement 8: Maternal health – weight management

Quality statement

Women with a body mass index (BMI) of 30 kg/m² or more at the 6–8 week postnatal check are offered a referral for advice on healthy eating and physical activity.

Rationale

The woman's eating habits and physical activity levels could influence the health behaviour of the wider family, including children who are developing habits that may remain with them for life. Supporting the woman in the postnatal period to change her eating habits and physical activity levels may improve her health, her infant's health and the health of the wider family. It may also improve the outcomes of future pregnancies.

Women who are obese during pregnancy face increased risks of complications that include gestational diabetes, miscarriage, pre-eclampsia, thromboembolism and maternal death. Risks for the infant include fetal death, stillbirth, shoulder dystocia, and macrosomia. Infants of obese women face health risks in childhood including diabetes and obesity in later life.

Quality measures

Structure

a) Evidence of local arrangements to ensure that women have their BMI assessed and recorded at the 6–8 week postnatal check.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that women with a BMI of 30 kg/m² or more at the 6–8 week postnatal check are offered a referral for advice on healthy eating and physical activity.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that the local workforce has appropriate numbers of

staff trained to deliver healthy eating and physical activity services to postnatal women.

Data source: Local data collection.

Process

a) The proportion of women who have their BMI recorded at the 6–8 week postnatal check.

Numerator – the number of women in the denominator who have their BMI recorded.

Denominator – the number of women who attend a 6–8 week postnatal check.

Data source: Local data collection.

b) The proportion of women with a BMI of 30 kg/m² or more at the 6–8 week postnatal check who are offered a referral for advice on healthy eating and physical activity.

Numerator – the number of women in the denominator who are offered a referral for advice on healthy eating and physical activity.

Denominator – the number of women with a BMI of 30 kg/m² or more who attend a 6–8 week postnatal check.

Data source: Local data collection.

c) The proportion of women with a BMI of 30 kg/m² or more at the 6–8 week postnatal check who accept a referral for advice on healthy eating and physical activity.

Numerator – the number of women in the denominator who accept a referral for advice on healthy eating and physical activity.

Denominator – the number of women with a BMI of 30 kg/m² or more who attend a 6–8 week postnatal check.

Data source: Local data collection.

Outcome

Women feel able to make informed decisions about healthy eating, physical activity and weight

management for themselves and their family.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women with a BMI of 30 kg/m² or more at the 6–8 week postnatal check to be offered a referral for advice on healthy eating and physical activity.

Healthcare practitioners offer women with a BMI of 30 kg/m² or more at the 6–8 week postnatal check a referral for advice on healthy eating and physical activity.

Commissioners ensure that they commission services that offer women with a BMI of 30 kg/m² or more at the 6–8 week postnatal check a referral for advice on healthy eating and physical activity.

Women who have a body mass index of 30 kg/m² or more at the 6–8 week postnatal check are offered a referral for advice on healthy eating and physical activity.

Source guidance

- [Maternal and child nutrition](#) (2008) NICE guideline PH11, recommendation 6
- [Weight management before, during and after pregnancy](#) (2010) NICE guideline PH27, recommendations 3 and 4

Definitions of terms used in this quality statement

Structured programme

Women should be offered a referral to an individual or group-based service that uses a structured programme. Services should deliver a structured programme that:

- addresses the reasons why women may find it difficult to lose weight, particularly after pregnancy
- is tailored to the needs of an individual or group

- combines advice on healthy eating and physical exercise (advising them to take a brisk walk or other moderate exercise for at least 30 minutes on at least 5 days of the week)
- identifies and addresses individual barriers to change
- provides ongoing support over a sufficient period of time to allow for sustained lifestyle changes.

Services should be delivered by an appropriately trained person. This is someone who can demonstrate expertise and competencies in healthy eating and/or physical activity, including weight management for women in the postnatal period. This may include midwives, health visitors, obstetricians, dietitians, GPs, nurses, midwifery assistants, support workers and those working in weight management programmes (commercial or voluntary).

Women who choose not to accept a referral should be given information about where they can get support on healthy eating and physical activity in future.

[Adapted with expert group consensus from NICE's guidelines on [weight management before, during and after pregnancy](#), recommendations 3 and 4, and [maternal and child nutrition](#), recommendation 6]

Equality and diversity considerations

Women should be able to access services that are appropriate to their cultural and religious beliefs, and that make relevant adjustments for anyone who has communication difficulties, and for those who don't speak or read English.

Quality statement 9: Emotional wellbeing and infant attachment

Quality statement

Women have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact.

Rationale

The baby's relationship with the mother (or main carer) has a significant impact on the baby's social and emotional development. In turn, the woman's ability to provide a nurturing relationship is partly dependent on her own emotional wellbeing. Regular assessment of the woman's emotional wellbeing and the impact of this on her attachment to her baby may lead to earlier detection of problems.

Quality measures

Structure

Evidence of local arrangements that women have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact.

Data source: Local data collection.

Process

a) Proportion of women whose emotional wellbeing, including emotional attachment to their baby, is assessed at each postnatal contact.

Numerator – the number of postnatal contacts in the denominator in which the mother's emotional wellbeing, including emotional attachment to the baby, is assessed.

Denominator – the number of postnatal care contacts.

Data source: Local data collection.

b) Proportion of women whose emotional wellbeing, including their emotional attachment to their baby, is assessed at a postnatal contact 5–7 days after the birth.

Numerator – the number of women whose emotional wellbeing, including their emotional attachment to their baby, is assessed at a postnatal contact 5–7 days after the birth.

Denominator – the number of women receiving a postnatal contact 5–7 days after the birth.

Data source: Local data collection.

c) Proportion of women whose emotional wellbeing, including their emotional attachment to their baby, is assessed at a postnatal contact 10–14 days after the birth (at the midwifery and health visitor handover when the woman and baby are discharged from the care of the community midwifery team to the care of the health visitor).

Numerator – the number of women whose emotional wellbeing, including their emotional attachment to their baby, is assessed at a postnatal contact 10–14 days after the birth.

Denominator – the number of women receiving a postnatal contact 10–14 days after the birth.

Data source: Local data collection.

d) Proportion of women whose emotional wellbeing, including their emotional attachment to their baby, is assessed at a postnatal contact 6–8 weeks after the birth.

Numerator – the number of women whose emotional wellbeing, including their emotional attachment to their baby, is assessed at a postnatal contact 6–8 weeks after the birth.

Denominator – the number of women receiving a postnatal contact 6–8 weeks after the birth.

Data source: Local data collection.

e) Proportion of women whose emotional wellbeing, including their emotional attachment to their baby, is assessed at a postnatal contact 16 weeks after the birth.

Numerator – the number of women whose emotional wellbeing, including their emotional attachment to their baby, is assessed at a postnatal contact 16 weeks after the birth.

Denominator – the number of women receiving a postnatal contact 16 weeks after the birth.

Data source: Local data collection.

Outcome

a) Incidence of postnatal mental health problems.

Data source: Local data collection.

b) Incidence of mother-to-baby emotional attachment problems.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place so that women are asked about their emotional wellbeing, including their mother-to-baby emotional attachment, assessed at each postnatal contact.

Healthcare practitioners ensure that women have their emotional wellbeing, including their mother-to-baby emotional attachment, assessed at each postnatal contact.

Commissioners ensure that they commission services that have local agreements to ensure women have their emotional wellbeing, including their mother-to-baby emotional attachment, assessed at each postnatal contact.

Women have their emotional wellbeing, including their relationship with their baby (called 'emotional attachment'), assessed at each postnatal contact.

Source guidance

Postnatal care up to 8 weeks after birth (2015) NICE guideline CG37 recommendations 1.2.22 [key priority for implementation] and 1.4.5

Definitions of terms used in this quality statement

Postnatal contacts

Women and their babies should receive the number of postnatal contacts that are appropriate to their care needs. A postnatal contact is a scheduled postnatal appointment that may occur in the woman or baby's home or another setting such as a GP practice, children's centre or this could be a hospital setting where women and/or the baby requires extended inpatient care.

Emotional wellbeing

Being happy and confident and not anxious or depressed.

[NICE's guideline on [social and emotional wellbeing: early years](#), glossary]

Mother-to-baby emotional attachment

This involves the formation of a secure bond between the mother and the baby, in which the mother responds sensitively and appropriately to the baby's signals, providing an environment in which the baby feels secure.

Equality and diversity considerations

Communication between women (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who don't speak or read English.

Quality statement 10: Maternal health – mental wellbeing

Quality statement

Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems.

Rationale

Women experience emotional changes in the immediate postnatal period which usually resolve within 10–14 days after the birth. Women who are still feeling low in mood, anxious, experiencing negative thoughts or lacking interest in their baby at 10–14 days after the birth may be at increased risk of mental health problems. These women should receive an assessment of their mental wellbeing.

Quality measures

Structure

Evidence of local arrangements for women in whom transient psychological symptoms ('baby blues') have not resolved at 10–14 days after the birth to have an assessment for mental health problems.

Data source: Local data collection.

Process

Proportion of women in whom transient psychological symptoms ('baby blues') have not resolved at 10–14 days after the birth who are assessed for mental health problems.

Numerator – the number of women in whom transient psychological symptoms ('baby blues') have not resolved at 10–14 days after the birth who are assessed for mental health problems.

Denominator – the number of women in whom transient psychological symptoms ('baby blues') have not resolved at 10–14 days after the birth.

Data source: Local data collection.

Outcome

Incidence of postnatal mental health problems.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women in whom transient psychological symptoms ('baby blues') have not resolved at 10–14 days after the birth to have an assessment for mental health problems.

Healthcare practitioners ensure that women in whom transient psychological symptoms ('baby blues') have not resolved at 10–14 days after the birth are assessed for mental health problems.

Commissioners ensure that they commission services with local arrangements for women in whom transient psychological symptoms ('baby blues') have not resolved at 10–14 days after the birth to have an assessment for mental health problems.

Women in whom 'baby blues' have not resolved at 10–14 days after the birth are assessed for mental health problems.

Source guidance

Postnatal care up to 8 weeks after birth (2015) NICE guideline CG37, recommendation 1.2.24 and 1.2.25

Definitions of terms used in this quality statement

Transient psychological symptoms ('baby blues')

Examples of symptoms of unresolved baby blues include tearfulness, feelings of anxiety and low mood.

[NICE's guideline on postnatal care up to 8 weeks after birth, recommendation 1.2.25]

Assessment for mental health problems

Assessment and diagnosis of a suspected mental health problem in the postnatal period should include:

- History of any mental health problem including in pregnancy or the postnatal period.
- Physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem.
- Alcohol and drug misuse.
- The woman's experience of pregnancy and any problems experienced by her, the fetus or baby.
- The other-baby relationship.
- Any past or present treatment for a mental health problem, and response to any treatment.
- Social networks and quality of interpersonal relationships.
- Living conditions and social isolation.
- Family history (first-degree relative) of mental health problems.
- Domestic violence and abuse, sexual abuse, trauma or childhood maltreatment.
- Housing, employment, economic and immigration status.
- Responsibilities as a carer for other children and young people or other adults.

[Adapted from NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.6.1]

Equality and diversity considerations

Communication between women (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who don't speak or read English.

Quality statement 11: Parent–baby attachment

Quality statement

Parents or main carers who have infant attachment problems receive services designed to improve their relationship with their baby.

Rationale

Problems with parent-to-baby attachment may result in the baby developing emotional, psychological or behavioural issues in childhood. Providing family-based interventions could improve attachment, thereby providing the building blocks for the child to develop healthy behaviours and mental wellbeing.

Quality measures

Structure

Evidence of local arrangements to ensure that parents or main carers with infant attachment problems receive services designed to improve their relationship with their baby.

Data source: Local data collection.

Process

Proportion of parents or main carers with infant attachment problems who receive services designed to improve their relationship with their baby.

Numerator – the number of parents or main carers with infant attachment problems who receive services designed to improve their relationship with their baby.

Denominator – the number of parents or main carers with infant attachment problems.

Data source: Local data collection.

Outcome

a) Emotional, behavioural and social wellbeing of developing babies.

Data source: Local data collection.

b) Parental or main carer satisfaction with services to support parenting skills.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that parents or main carers with infant attachment problems receive services designed to improve their relationship with their baby.

Healthcare practitioners offer parents or main carers with infant attachment problems services designed to improve their relationship with their baby.

Commissioners ensure that they commission services that have systems in place to offer parents or main carers with infant attachment problems services designed to improve their relationship with their baby.

Parents or main carers who are having difficulties forming a bond with their child are able to receive services designed to improve their relationship with their baby.

Source guidance

- [Postnatal care up to 8 weeks after birth](#) (2015) NICE guideline CG37, recommendation, recommendation 1.4.8
- [Social and emotional wellbeing: early years](#) (2012) NICE guideline PH40, recommendations 2 and 3

Definitions of terms used in this quality statement

Services to improve parent–baby relationships

Services have the aim of promoting emotional attachment and improving parenting skills. Services

should be tailored to the needs of the family and baby and may include the woman, partner and wider family. Services should be sensitive to a wide range of attitudes, expectations and approaches in relation to parenting. NICE's guideline on [social and emotional wellbeing: early years](#) provides guidance about the types of services which may provide additional parenting support, for example a series of intensive home visits delivered by an appropriately trained nurse, baby massage and video interaction.

Main carer

For the majority of babies the main carer will be the mother. For some babies the main carer could be a close relative, for example the baby's father or grandparent, or for looked-after babies this could be a foster parent.

Equality and diversity considerations

In order to promote equality, the parents of babies who are vulnerable to poor parent–baby relationships may require additional intensive support. Services should take into account the parent's first language, and this may influence the interventions to achieve specified goals around the baby's communication, speech and language development.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

See NICE's [how to use quality standards](#) for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#).

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between health and social care practitioners and women, and if appropriate their partner and family, is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Topic Expert Group to develop the quality standard statements and measures.

- [Postnatal care up to 8 weeks after birth](#) (2015) NICE guideline CG37
- [Antenatal and postnatal mental health: clinical management and service guidance](#) (2014) NICE guideline CG192
- [Social and emotional wellbeing: early years](#) (2012) NICE guideline PH40
- [Bacterial sepsis following pregnancy: green-top guideline no. 64b](#) (2012) Royal College of Obstetricians and Gynaecologists
- [Weight management before, during and after pregnancy](#) (2010) NICE guideline PH27
- [Maternal and child nutrition](#) (2008) NICE guideline PH11

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health (2011) [Health visitor implementation plan 2011–15: a call to action](#)
- Department of Health (2010) [Maternity and early years](#)
- Department of Health (2010) [Tackling health inequalities in infant and maternal health outcomes: report of the Infant Mortality National Support Team](#)
- Department of Health (2009) [Healthy lives, brighter futures – the strategy for children and young people's health](#)
- Department of Health (2009) [Healthy child programme: pregnancy and the first five years of life](#)

- Department of Health (2009) [Delivering high quality midwifery care: the priorities, opportunities and challenges for midwives](#)
- Department of Health (2007) [Maternity matters: choice, access and continuity of care in a safe service](#)

Definitions and data sources for the quality measures

- Care Quality Commission (2018) [Maternity services survey](#)
- Healthcare Quality Improvement Partnership (undertaken by [MBRRACE-UK](#)) [Confidential Enquiries into Maternal Deaths](#)
- NHS Digital [Maternity services data set](#)
- Healthcare Quality Improvement Partnership (undertaken by [MBRRACE-UK](#)) [Perinatal mortality surveillance report](#)
- Office for National Statistics (2017) [Unexplained deaths in infancy, England and Wales: 2017](#)
- Public Health England [Breastfeeding statistics](#)
- Health and Social Care Information Centre [Children and Young People's Health Services Secondary Uses Data Set](#)
- Department of Health (2007) [Maternity matters: choice, access and continuity of care in a safe service](#)
- [Infant feeding survey 2010](#)

Related NICE quality standards

Published

- [Developmental follow-up of children and young people born preterm](#) (2018) NICE quality standard 169
- [Antenatal and postnatal mental health](#) (2016) NICE quality standard 115
- [Bronchiolitis in children](#) (2016) NICE quality standard 122
- [Diabetes in pregnancy](#) (2016) NICE quality standard 109
- [Preterm labour and birth](#) (2016) NICE quality standard 135
- [Intrapartum care](#) (2015) NICE quality standard 105
- [Neonatal infection](#) (2014) NICE quality standard 75
- [Fever in under 5s](#) (2014) NICE quality standard 64
- [Constipation in children and young people](#) (2014) NICE quality standard 62
- [Inducing labour](#) (2014) NICE quality standard 60
- [Jaundice in newborn babies under 28 days](#) (2014) NICE quality standard 57
- [Multiple pregnancy: twin and triplet pregnancies](#) (2013) NICE quality standard 46
- [Hypertension in pregnancy](#) (2013) NICE quality standard 35
- [Caesarean section](#) (2013) NICE quality standard 32
- [Antenatal care](#) (2012) NICE quality standard 22
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15
- [Neonatal specialist care](#) (2010) NICE quality standard 4
- [Venous thromboembolism in adults: reducing the risk in hospital](#) (2010) NICE quality standard 3

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topic scheduled for future development:

- Faltering growth. NICE quality standard. Publication expected June 2020.

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Update information

June 2015: This quality standard has been updated to ensure alignment with the NICE guidelines on [postnatal care up to 8 weeks after birth](#) and [antenatal and postnatal mental health](#), which are development sources for this quality standard. The guideline on postnatal care was updated in December 2014 to review the evidence on co-sleeping and sudden infant death syndrome, and new recommendations were added. The guideline on antenatal and postnatal mental health was also updated in December 2014.

In particular, quality statement 4 on safer infant sleeping has been updated in line with new recommendations 1.4.47–9 in the postnatal care guideline. For more information about the changes to the postnatal care guideline, see the [update information](#) section in the guideline on postnatal care.

Minor changes since publication

November 2019: The definitions for statement 3 have been changed to align with the updated NICE guideline on [fever in under 5s](#). References, data sources and policies have also been updated throughout.

December 2016: Data source updated for statement 5.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE Pathway on [postnatal care](#).

NICE produces guidance, standards and information on commissioning and providing high quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Royal College of Paediatrics and Child Health](#)

- Institute of Health Visiting
- Maternal OCD
- Royal College of General Practitioners (RCGP)
- Royal College of Midwives
- Royal College of Nursing (RCN)